STATE OF CONNECTICUT
DEPARTMENT OF SOCIAL SERVICES
OFFICE OF LEGAL COUNSEL, REGULATIONS AND ADMINISTRATIVE HEARINGS
55 FARMINGTON AVENUE
HARTFORD, CT 06105-3725

[redacted]
Signature Confirmation

[redacted]
Request # 122617

NOTICE OF DECISION
PARTY

[redacted]

PROCEDURAL BACKGROUND

[redacted], 2018, the Department of Social Services (the "Department") sent [redacted] (the "Appellant") a Notice of Action ("NOA") granting her medical assistance application for benefits under the Husky C Individual Receiving Home and Community Based Services Medicaid Program ("W01"), specifically, the Connecticut Home Care Program for Elders Medicaid Waiver ("CHCPE") effective [redacted] 2018.

[redacted] 2018, [redacted], the Appellant's daughter and Power of Attorney (the "POA") requested an administrative hearing to contest the Department's decision to deny community based services for [redacted] 2018 through [redacted] 2018.

[redacted], 2018, the Office of Legal Counsel, Regulations, and Administrative Hearings ("OLCRAH") issued a notice scheduling the administrative hearing for [redacted] 2018.

[redacted], 2018, the Appellant's POA requested postponement of the hearing.

[redacted], 2018, OLCRAH issued a notice rescheduling the hearing for [redacted] 2018.

[redacted], 2018, in accordance with sections 17b-60, 17b-61 and 4-176e to 4-189, inclusive, of the Connecticut General Statutes, OLCRAH held an administrative hearing. The following individuals were present at the hearing:

[redacted], Appellant's POA
Turquoise McBride, Department's Representative
Veronica King, Hearing Officer

The Appellant was not present.

The hearing record remained open for the submission of additional evidence. On [redacted] 2018, the record closed.

STATEMENT OF THE ISSUE

The issue to be decided is whether the Department's decision to begin payment for home and community based services under the CHCPE effective [redacted] 2018 was correct.

FINDINGS OF FACT

1. The Appellant is 98 years old (DOB [redacted]) and lives alone. (Exhibit 7: Notes from Alternative Care Unit ["ACU"] and Hearing Record)

2. Beginning [redacted] 2017, the Appellant received caregiver services twenty four hours per day in her home which she paid for from her private funds. (Exhibit 7 and Hearing Record)

3. Recipients of the CHCPE must qualify for Medicaid under the W01 program meeting the asset and financial criteria under Medicaid. (Department Representative's Testimony)

4. The Medicaid assets limit it is $1,600.00. (Department's Representative's Testimony and Hearing Record)

5. [redacted], 2017, the Appellant applied for the W01 Medicaid program. The application was denied on [redacted]8 because the Appellant assets were over the Medicaid assets limit criteria. (Exhibit 8: Case Notes screen prints and Hearing Record)

6. [redacted], 2018, the Appellant reapplied for the W01 Medicaid program. (Exhibit 2: W1LTC Long Term Care/ Waiver Application form, Exhibit 8 and Hearing Record)

7. On [redacted], 2018, the Department issued a W1348LTC Verification We Need form ("W1348LTC") requesting verifications to establish eligibility by [redacted]18. (Exhibit 3: W1348LTC, [redacted]18)

8. [redacted] 2017 the Appellant transferred $5,000 to her granddaughter's CHET account. The Department determined that the transfer was an improper transfer and a penalty for improper transfer of assets would be imposed. The Department

explained to the Appellant's POA that the money could be repaid and assets would have to be reduced or penalty could be accepted. (Exhibit 8)

9. [redacted], 2018, the Appellant's POA deposit $5,000 onto the Appellant's People's bank account [redacted]. (Exhibit 11: Appellant's assets verifications and [redacted]8 letter)

10. [redacted], 2018, the Department issued and W1348LTC requesting verification of reduced assets by [redacted]/18. (Exhibit 4: W1348LTC, [redacted]/18)

11. [redacted], 2018, the Department received via fax the Appellant's POA letter dated [redacted]/18 and verification of the Appellant's current assets. (Exhibit 8, Exhibit 11 and Hearing Record)

12. [redacted], 2018, the Appellant's People's bank account [redacted] had a balance of $425.49. (Exhibit 11)

13. [redacted], 2018, the Department reviewed the verifications received on [redacted]/18 and determined that the Appellant became financial eligible as [redacted] of 2018. (Exhibit 8 and Hearing Record)

14. [redacted], 2018, the Department requested the W1518 Home and Community Based Services Waiver referral for the CHCPE program ("W1518"). (Exhibit 8)

15. [redacted], 2018, the Department authorized home care services for the Appellant effective [redacted], 2018. (Exhibit 6: W1518, Exhibit 7 and Exhibit 8)

16. [redacted], 2018, the Department issued a notice of action to the Appellant. The notice stated the Department approved Medicaid under the W01 effective [redacted] 2018. The notice stated, "You are on the Connecticut Home Care Program for Elders Medicaid Waiver." (Exhibit 5: Notice of Action, [redacted]/18)

17. The Appellant's POA seeks payment for home care services under the CHCPE program effective [redacted] 2018. (Appellant's POA Testimony)

CONCLUSIONS OF LAW

1. Connecticut General Statute ("C.G.S.") § 17b-2 provides that the Department of Social Services is designated as the state agency for the administration of the Medicaid program pursuant to Title XIX of the Social Security Act.

2. State Statute provides that the Commissioner of Social Services shall administer the Connecticut home-care program for the elderly state-wide in order to prevent the institutionalization of elderly persons (1) who are recipients of medical assistance, (2)

who are eligible for such assistance, (3) who would be eligible for medical assistance if residing in a nursing facility, or (4) who meet the criteria for the state-funded portion of the program under subsection (i) of this section. For purposes of this section, a long-term care facility is a facility that has been federally certified as a skilled nursing facility or intermediate care facility. The commissioner shall make any revisions in the state Medicaid plan required by Title XIX of the Social Security Act prior to implementing the program. The program shall be structured so that the net cost to the state for long-term facility care in combination with the services under the program shall not exceed the net cost the state would have incurred without the program. The commissioner shall investigate the possibility of receiving federal funds for the program and shall apply for any necessary federal waivers. A recipient of services under the program, and the estate and legally liable relatives of the recipient, shall be responsible for reimbursement to the state for such services to the same extent required of a recipient of assistance under the state supplement program, medical assistance program, temporary family assistance program or supplemental nutrition assistance program. Only a United States citizen or a noncitizen who meets the citizenship requirements for eligibility under the Medicaid program shall be eligible for home-care services under this section, except a qualified alien, as defined in Section 431 of Public Law 104-193, admitted into the United States on or after August 22, 1996, or other lawfully residing immigrant alien determined eligible for services under this section prior to July 1, 1997, shall remain eligible for such services. Qualified aliens or other lawfully residing immigrant aliens not determined eligible prior to July 1, 1997, shall be eligible for services under this section subsequent to six months from establishing residency. Notwithstanding the provisions of this subsection, any qualified alien or other lawfully residing immigrant alien or alien who formerly held the status of permanently residing under color of law who is a victim of domestic violence or who has intellectual disability shall be eligible for assistance pursuant to this section. Qualified aliens, as defined in Section 431 of Public Law 104-193, or other lawfully residing immigrant aliens or aliens who formerly held the status of permanently residing under color of law shall be eligible for services under this section provided other conditions of eligibility are met. [C.G.S. 17b-342(a)]

3. Uniform Policy Manual ("UPM") § 2540.92(A) provides that this group includes individual who:

    1. Would be eligible for MAABD if residing in a long term care facility (LTCF); and
    2. Qualify to receive home and community-based services under a waiver approved by the Centers for Medicare and Medicaid Services; and
    3. Would, without such services, require care in an LTCF.

    The Department correctly determined that the Appellant must qualify for Medicaid program to receive home and community-base services.

4. UPM § 4005.10 provides that the Medicaid asset limit for a needs group of one is $1, 600.00.

UPM § 4000.01 defines available assets as cash or any item of value which is actually available to the individual or which the individual has the legal right, authority or power to obtain, or to have applied for , his or her general or medical support.

UPM § 4005.05 (D) (1) provides that the Department compares the assistance unit's equity in counted assets with the program asset limit when determining whether the unit is eligible for benefits.

UPM § 4005.15 provides that in the Medicaid program, at the time of application, the assistance unit is ineligible until the first day of the month in which it reduces its equity in counted assets to within the asset limit.

The Department correctly determined that the Appellant's balance at the People's bank account [redacted]s counted towards the Medicaid asset limit of $1600.

The Department correctly determined that the Appellant's assets were reduced to below $1600 in [redacted]f 2018.

The Department incorrectly determined that the Appellant became financially eligible for Medicaid as of [redacted] 2018.

5. Regulation provides that persons seeking home care services may initiate a screening for program participation by submitting a Home Care Request Form or by calling the department. Individuals or client representatives are responsible for assuring that all information necessary for determining eligibility including, but not be limited to, completing and submitting a program financial application and providing any required verifications, is submitted on their behalf to the department. Authorization for home care services shall not be granted, nor a plan of care implemented, until complete information has been provided and a financial and functional eligibility determination has been issued by the department. Failure to provide required information and non-cooperation with any of the program requirements shall be grounds for denial or discontinuance from the Connecticut Home Care Program. [Conn. Agency Regs. § 17b-342-1(g)]

Regulation defines "home care services" as any combination of community based services and home health services as defined in sections 17b-342-1(b)(9) and (21) of the Regulations of the State Agencies which enable elders to live in noninstitutional settings. Such services may be provided to elders living in private homes, congregate housing, assisted living demonstration project facilities, housing and urban development facilities, private facilities and homes for the aged and other community living situations as long as the services needed are not considered a regular component of the services of the community living situation. [Conn. Agency Regs. § 17b-342-1(b)(20)]

Regulation provides for (C) Category Type 3: This category applies to elders who, but for the provision of home care services, would require nursing facility care funded by Medicaid. This category type is available to elders who meet the financial and functional eligibility criteria for Medicaid under the federal waiver as defined in the department's Uniform Policy Manual section 2540.92. [Conn. Agency Regs. § 17b-342-1(c)(4)(C)]

Regulation provides that if the department determines that a plan of care is feasible and cost-effective under the program, the elderly person may remain in the community with assistance provided under the Connecticut Home Care Program. If home care is desired, the plan of care shall be authorized by the department. [Conn. Agency Regs. § 17b-342-1(d)(6)]

Regulation provides that all home care services provided to individual under the Connecticut Home Care Program shall be authorized in accordance with procedures established by the department prior to the delivery of the services. [Conn. Agency Regs. § 17b-342-3(a)(1)]

UPM § 8040.10(F)(2) provides that the beginning date of assistance is the later of the following dates: the earliest date that the plan of care can be implemented after all eligibility requirements are met.

UPM § 1505.35 provides for application processing standards and provides in part that (A) 1. Prompt action is taken to determine eligibility on each application filed with the Department. 2. Reasonable processing standards are established to assure prompt action on applications. (C) (1)(c)(2) promptness standards are established as maximum time period of forty-five calendar days for AABD or MA applicants applying on basis of age or blindness.

The Department correctly processed the Medicaid application within the promptness standard maximum time period of forty-five calendar days from the [redacted]18 application day.

The Department correctly authorized home care services under the CHCPE effective [redacted], 2018 upon the approval of Medicaid under the W01.

6. Regulations provides that reimbursement is not available for services arranged by program clients or representatives, access agencies, assisted living service agencies or service providers without prior approval by the department or department designee. [Conn. Agency Regs. § 17b-342-3(a)(11)]

The Department correctly determined home care services provided prior to the [redacted], 2018 authorization date for services under the CHCPE will not be paid for by the Department.

DISCUSSION

The Appellant's POA worked diligent on the Appellant's application, she promptly responded to the Department's requests of verifications. The issue of the hearing is the effective date of the home care services. The Department determination that the Appellant become financial eligible for Medicaid on [redacted] 2018 was incorrect as she reduced her assets on [redacted] 2018 and regulation says that she would be eligible for Medicaid on the first day of the month in which it reduces the assets to within the asset limit ([redacted] 2018). Unfortunately, it would not affect the date of authorized CHCPE services. Regulations are clear and say that all home care services shall be effective when authorized by the Department and in this case, the Department authorized services on [redacted], 2018. The Department correctly processed the application and authorized services under the CHCPE within the permissible time period by regulation.

DECISION

The Appellant's appeal is **DENIED.**

Veronica King
Hearing Officer

Cc: Musa Mohamud, DSS Operation Manager DO#10 Hartford
Judy Williams, DSS Operation Manager DO#10 Hartford
Jessica Carroll, DSS Operation Manager DO#10 Hartford
Turquoise McBride, DSS Hearing Liaison DO#Hartford

RIGHT TO REQUEST RECONSIDERATION

The appellant has the right to file a written reconsideration request within **15** days of the mailing date of the decision on the grounds there was an error of fact or law, new evidence has been discovered or other good cause exists. If the request for reconsideration is granted, the appellant will be notified within 25 days of the request date. No response within 25 days means that the request for reconsideration has been denied. The right to request a reconsideration is based on §4-181a (a) of the Connecticut General Statutes.

Reconsideration requests should include specific grounds for the request: for example, indicate what error of fact or law, what new evidence, or what other good cause exists.

Reconsideration requests should be sent to: Department of Social Services, Director, Office of Administrative Hearings and Appeals, 55 Farmington Avenue Hartford, CT 06105.

RIGHT TO APPEAL

The appellant has the right to appeal this decision to Superior Court within 45 days of the mailing of this decision, or 45 days after the agency denies a petition for reconsideration of this decision, provided that the petition for reconsideration was filed timely with the Department. The right to appeal is based on §4-183 of the Connecticut General Statutes. To appeal, a petition must be filed at Superior Court. A copy of the petition must be served upon the Office of the Attorney General, 55 Elm Street, Hartford, CT 06106 or the Commissioner of the Department of Social Services, 55 Farmington Avenue Hartford, CT 06105. A copy of the petition must also be served on all parties to the hearing.

The 45 day appeal period may be extended in certain instances if there is good cause. The extension request must be filed with the Commissioner of the Department of Social Services in writing no later than 90 days from the mailing of the decision. Good cause circumstances are evaluated by the Commissioner or the Commissioner's designee in accordance with §17b-61 of the Connecticut General Statutes. The Agency's decision to grant an extension is final and is not subject to review or appeal.

The appeal should be filed with the clerk of the Superior Court in the Judicial District of New Britain or the Judicial District in which the appellant resides.